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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
-USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5496**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		c. CITY OR TOWN PACIFIC	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE VET ADM HOSPITAL		Length of stay in lb 76 DAYS	
d. STREET ADDRESS RT # 1, BOX 46		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CEICEL L Middle HOWLAND Last		4. DATE OF DEATH Month 6 Day 12 Year 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-6-08
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY WORKER	
11. BIRTHPLACE (City and state or country) ROCKPORT, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM J. HOWLAND		14. MOTHER'S MAIDEN NAME MARY MC CANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 499-26-3450	
17. INFORMANT VA HOP. RECORDS. 915 N GRAND. ST. LOUIS.		Address MISSOURI.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH UNK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY EMPHYSEMA SEVERE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 4:05 A.M. Month 6 Day 12 Year 57			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION VA		COUNTY STATE	
21. / attended the deceased from 3-28-57 to 6-12-57 and last saw As alive on 6-12-57		Death occurred at 4:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) M. D. VAH. ST. LOUIS, MISSOURI		22b. ADDRESS Pearl, Illinois	
22c. DATE SIGNED 6-12-57			
23a. BURIAL, CREMATORY, REMOVAL, ETC. Removal		23b. NAME OF CEMETERY OR CREMATORY Pearl III.	
23c. LOCATION (City, town, or county) (State) Pearl, Illinois			
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. JUN 13 '57	
26. REGISTRAR'S SIGNATURE Edythe A. Bridges			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....

Signature of Student Embalmer

Signed

Harry Schuman

Licensed Embalmer No. *✓*

P. O. Address *5611A*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.